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In the July 2000 issue: **Vol. 40, No. 7**

CDC issues Adjunct Recommendations regarding the 2000-01 influenza season

Unfortunately, rumors of a delay and potential shortage of influenza vaccine for the coming season are true. Lower than anticipated production yields for this year's influenza A (H3N2) vaccine component are partially responsible for the projected delay. This delay, and perhaps a less-than-optimum supply of vaccine, has prompted the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) to issue modified recommendations for the upcoming influenza season:

1. Organized influenza vaccination campaigns should be delayed until early to mid-November.
2. Available vaccine should be given first to persons at high risk for complications from the flu and to their close contacts. This is especially important for:
   a) young children with chronic health conditions who are receiving influenza vaccine for the first time and who require two doses, and
   b) health care staff and patients of nursing homes, hospitals and other health care settings.
3. For the 2000-01 season, it is particularly important for vaccine providers to continue to administer vaccine after mid-November.
4. Influenza vaccine purchasers should refrain from placing duplicate orders with multiple companies to minimize vaccine wastage.
5. In 2000, the ACIP broadened its influenza vaccine recommendations to include all persons aged 50-64 years. In the context of a potential vaccine shortage, it would be appropriate for providers to focus primarily on persons with high-risk conditions rather than this entire age group.
6. Antiviral drugs are NOT a substitute for influenza vaccine. The CDC and ACIP do not support their routine and widespread use because this is an untested and expensive strategy that could result in large numbers of persons experiencing adverse events.

The full text of the Adjunct ACIP Influenza Vaccine Recommendations for 2000-01 can be found at the following web address: www.cdc.gov/epo/mmwr/preview/mmwrhtml/mm4927a4.htm

Coxiella burnetti as a bioterrorist agent

Following the Gulf War and the collapse of the Soviet Union the U.S. intelligence community became aware that the development of biological weaponry is much more widespread than previously believed. Events such as the bombings of the World Trade Center in 1993, the Murrah Federal Building in Oklahoma City in 1995, and the U.S. Embassies in Kenya and Tanzania in 1998 have heightened fears of terrorist attacks. Future terrorist activities may continue to involve bombs and firearms, but may also include weapons utilizing biological agents. Improving surveillance for infectious diseases to assure rapid recognition of such an attack is an important step in minimizing the impact of a weaponized biological agent. One such effort is to raise the awareness level of bioterrorism issues among clinicians. This, the fourth EpiLog article in a series, will continue to discuss biologic agents that are thought most likely to be used in a bioterrorist attack. Public health and military authorities have determined that *Coxiella burnetti* is one such agent.

The disease "Q Fever" was first described in Australia but has been reported from all continents; it was called "Query fever" because the causative agent was initially unknown. The naturally-occurring form of Q Fever is a zoonotic disease caused by the rickettsia *Coxiella burnetii*. Its natural reservoir is the reproductive tract of sheep, cattle and goats. The disease is seldom reported, but its incidence is believed to be greater than that reported. Many mild cases go undiagnosed due to limited clinical suspicion and a lack of capable testing laboratories. The organism is resistant to heat and desiccation and is highly infectious by the aerosol route. A single inhaled organism may produce clinical illness. A bioterrorist attack with Q Fever would likely occur by aerosolizing the organism, causing a respiratory disease similar to the naturally-occurring form.

Human infection with *C. burnetii* is usually acquired by inhalation of contaminated dust particles. The incubation period for the disease is usually 10-40 days. Q Fever, in its classic form, begins with a sudden onset of a self-limiting, febrile illness lasting 2 days to 2 weeks, presenting with headache, fatigue, and myalgia. Pneumonia manifested by an abnormal chest x-ray occurs in half of all patients, but only half of these (25%) will have cough or rales. Chest x-ray abnormalities, when present, are patchy infiltrates involving a portion of one lobe giving a homogeneous ground glass appearance that may resemble viral or mycoplasma pneumonia. The lesions tend to occur in the peribronchial and alveolar areas rather than the hilar regions. Uncommon complications include chronic hepatitis, culture-negative endocarditis, aseptic meningitis, encephalitis and osteomyelitis. Q Fever is characterized by high morbidity but the

case fatality rate in untreated cases is usually less than one percent.

Q Fever must be differentiated from pneumonia caused by other causes of community-acquired pneumonia such as *S. pneumoniae*, *Mycoplasma pneumoniae*, *Legionella pneumophila*, *Chlamydia psittaci*, and *Chlamydia pneumoniae*. Identification of organisms by examination of sputum is not helpful. Isolation of the organism is impractical, as the organism is difficult to culture and poses a significant hazard to laboratory workers. Serological tests for Q Fever include identification of antibody to *C. burnetii* by indirect fluorescent antibody (IFA), enzyme-linked immunosorbent assay (ELISA) and complement fixation. Specific IgM antibodies may be detectable as early as the second week after onset of illness. As the disease is not transmitted person-to-person, only standard isolation precautions are needed to protect healthcare workers. Most cases of acute Q Fever will eventually resolve spontaneously without antibiotic treatment. Tetracycline (500mg every 6hr) or doxycycline (100mg every 12hr) for 5-7 days will shorten the duration of illness, and fever usually disappears within one to two days after treatment is begun.

Prompt recognition of unusual clusters or presentations of pneumonia by clinicians is essential to mount an effective public health response, decrease active infections with prophylaxis, and relieve public anxiety about outbreaks.

Immunization Update Teleconference

The Centers for Disease Control and Prevention is presenting a live, interactive teleconference, **Immunization Update 2000, on Thursday, September 14th , 9:00-11:45am.** The tele-conference is being co-sponsored by Region X of the U.S. Public Health Service and Public Health – Seattle & King County, and will be held at the Blanchard Plaza Building located at 6th and Blanchard in downtown Seattle.

The program will provide updates on new vaccines and vaccine combinations; new vaccine recommendations from the Advisory Committee on Immunization Practices (ACIP); and why and how to assess the immunization levels in your practice. CME/CEU credits will be offered for a variety of professions. If you are interested in receiving registration information, please call Amy Patton, 206-205-5803, or email amy.patton@metrokc.gov.

New Hepatitis Resource Center a resource for patients with hepatitis C

The Hepatitis Education Project is pleased to announce the opening of the Hepatitis Resource Center, located at 4603 Aurora Ave. N. in the Fremont neighborhood. This center provides education, support, and guidance to Seattle-area residents who are affected by hepatitis C. Currently open four days a week, the center has trained volunteers on hand to answer questions and help clients locate resources. Also available at the center are patient-oriented books on hepatitis and liver disease, educational videos, an Internet station for finding information on-line, medical abstracts, news articles, information on treatment (pharmaceutical and holistic), and local support group information. The center also holds bimonthly orientations for people who have recently been diagnosed with hepatitis C.

To learn about walk-in hours or to receive information about the Resource Center, support groups, or new patient orientations, please call the Hepatitis Resource Center at 206-732-0311.

Disease Reporting (area code 206)
AIDS.....296-4645
Communicable Disease.....296-4774
STDs.....731-3954
Tuberculosis.....731-4579
24-hr Report Line 296-4782

Hotlines:
CD Hotline.....296-4949
HIV/STD Hotline.....205-STDS

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http://www.metrokc.gov/health

Reported Cases of Selected Diseases Seattle-King County 2000

	Cases Reported In June		Cases Reported Through June	
	2000	1999	2000	1999
VACCINE-PREVENTABLE DISEASES				
Mumps	0	0	3	1
Measles	0	0	2	1
Pertussis	17	8	130	367
Rubella	0	0	1	2
SEXUALLY TRANSMITTED DISEASES				
Syphilis	11	7	41	43
Gonorrhea	74	67	526	463
Chlamydial infections	360	342	2229	1906
Herpes, genital	69	74	428	345
Pelvic Inflammatory Disease	17	23	113	134
Syphilis, late	0	2	15	19
ENTERIC DISEASES				
Giardiasis	22	11	114	83
Salmonellosis	13	72	102	141
Shigellosis	2	7	111	29
Campylobacteriosis	28	28	145	117
E.coli O157:H7	12	0	19	14
HEPATITIS				
Hepatitis A	3	28	59	68
Hepatitis B	5	9	23	21
Hepatitis C/non-A, non-B	1	0	4	2
AIDS	24	29	120	115
TUBERCULOSIS	13	4	61	46
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae B (cases < 5 years of age)	0	0	0	0
Meningococcal disease	1	0	9	11